

(12) INTERNATIONAL APPLICATION PUBLISHED UNDER THE PATENT COOPERATION TREATY (PCT)

(19) World Intellectual Property Organization
International Bureau(43) International Publication Date
21 August 2003 (21.08.2003)

PCT

(10) International Publication Number
WO 03/068095 A1(51) International Patent Classification⁷: **A61B 18/14**

(21) International Application Number: PCT/US03/04139

(22) International Filing Date: 12 February 2003 (12.02.2003)

(25) Filing Language: English

(26) Publication Language: English

(30) Priority Data:
60/356,612 12 February 2002 (12.02.2002) US(63) Related by continuation (CON) or continuation-in-part (CIP) to earlier application:
US 60/356,612 (CON)
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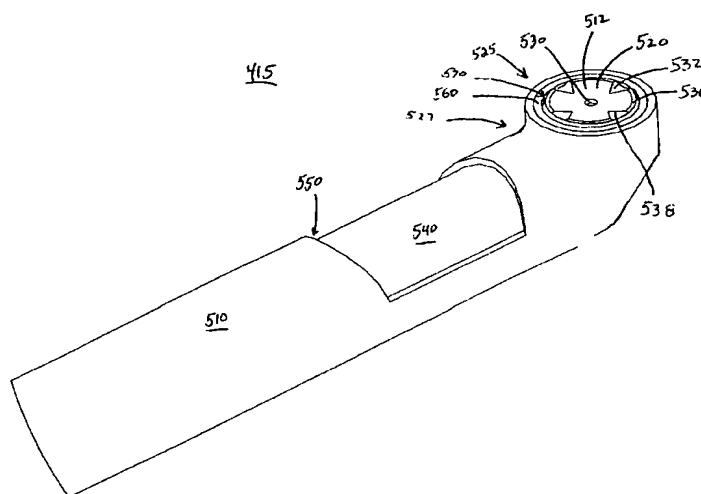
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(81) Designated States (national): AE, AG, AL, AM, AT, AU, AZ, BA, BB, BG, BR, BY, BZ, CA, CH, CN, CO, CR, CU, CZ, DE, DK, DM, DZ, EC, EE, ES, FI, GB, GD, GE, GH, GM, HR, HU, ID, IL, IN, IS, JP, KE, KG, KP, KR, KZ, LC, LK, LR, LS, LT, LU, LV, MA, MD, MG, MK, MN, MW, MX, MZ, NO, NZ, OM, PH, PL, PT, RO, RU, SD, SE, SG, SK, SL, TJ, TM, TN, TR, TT, TZ, UA, UG, US, UZ, VN, YU, ZA, ZM, ZW.

(84) Designated States (regional): ARIPO patent (GH, GM, KE, LS, MW, MZ, SD, SL, SZ, TZ, UG, ZM, ZW), Eurasian patent (AM, AZ, BY, KG, KZ, MD, RU, TJ, TM), European patent (AT, BE, BG, CH, CY, CZ, DE, DK, EE, ES, FI, FR, GB, GR, HU, IE, IT, LU, MC, NL, PT, SE, SI, SK, TR), OAPI patent (BF, BJ, CF, CG, CI, CM, GA, GN, GQ, GW, ML, MR, NE, SN, TD, TG).

[Continued on next page]

(54) Title: RADIOFREQUENCY ARTHROSCOPIC ABLATION DEVICE



(57) Abstract: A surgical device includes an elongated shaft having first and second electrically isolated electrodes coupled to the shaft such that an exposed portion of the second electrode is disposed around only part of a circumference of the elongated shaft, and includes a portion that is spaced proximally from the first electrode. Another surgical device also includes an elongated shaft having first and second electrically isolated electrodes coupled to the shaft, wherein the shaft includes a first side, and exposed surfaces of the first and second electrodes are side-facing toward the first side. Various embodiments of a "cool back" are provided, allowing arthroscopic surgery on a first side of a device without tissue effects on a back side of the device.

WO 03/068095 A1

WO 03/068095 A1



Published:

— with international search report

For two-letter codes and other abbreviations, refer to the "Guidance Notes on Codes and Abbreviations" appearing at the beginning of each regular issue of the PCT Gazette.

RADIOFREQUENCY ARTHROSCOPIC ABLATION DEVICE

Cross-Reference to Related Applications

5 The present application claims priority from U.S. Patent Application Serial No. 60/356,612, filed February 12, 2002, and titled "Arthroscopic Ablation Device," the entire contents of which are incorporated herein by reference.

Technical Field

10 Implementations relate to surgical devices and methods for applying thermal and/or electrical energy to organic material such as biological tissue to modify the characteristics of the tissue for therapeutic purposes. More particularly, disclosed implementations are directed to electrosurgical devices utilizing radio frequency ("RF") energy to cut, coagulate, and/or ablate tissue during a medical procedure for
15 treatment and therapy.

Background

Traditional open surgery is performed to repair various joints and orthopedic problems throughout the human body. Open surgery often has long recovery times
20 with large scars and requires intensive rehabilitation. There is a large cost associated with performing these procedures, including operating room time, personnel needed, and use of medical materials.

Arthroscopic surgery is becoming increasingly popular, compared to traditional open surgery, because arthroscopic surgery generally does less damage, is
25 less invasive, is safer, and produces less scarring in and around joints. Further, compared to traditional open surgery, arthroscopic surgery results in faster healing and a quicker return of a patient to full productivity, and reduces costs.

Summary

An apparatus and method are disclosed, for example, to selectively cut and ablate body tissue during a medical procedure such as arthroscopic surgery. The apparatus and method are configured and used for effective cutting and ablation of target tissue while giving the surgeon a precise and controlled surface for scraping tissue from bone or removing tissue within the surgical field for appropriate treatment and therapy. The apparatus can direct the energy source (for example, RF) to the tissue (for example, a tendon or a ligament) and apply RF to relatively cleanly and smoothly ablate the tissue. The apparatus can target certain tissues to be treated with high temperatures while protecting non-targeted tissues from thermal effect, thereby increasing the viability of tissues and promoting complete recovery. Accordingly, some procedures that have been considered too awkward or difficult to perform effectively by arthroscopy can now be performed more effectively using arthroscopic devices. The apparatus and method are applicable in a wide variety of medical procedures on a wide range of different bodily tissues. The apparatus is also simple and inexpensive to manufacture, and is compatible with conventional systems and procedures.

According to one aspect, a surgical device includes an elongated shaft, a first electrode coupled to the shaft, and a second electrode coupled to the shaft. The second electrode is electrically isolated from the first electrode, includes an exposed portion that is disposed around only part of a circumference of the elongated shaft, and includes a portion that is spaced proximally from the first electrode.

Embodiments of this aspect may include one or more of the following features.

A conductor includes the second electrode, the conductor being disposed around only a portion of the circumference of the elongated shaft. A layer of insulation is disposed over at least a portion of the conductor and includes a window that defines the exposed portion of the second electrode. The layer of insulation is also disposed over at least a designated part of the elongated shaft around which the

conductor is not disposed, wherein the designated part provides an insulated area that is configured to shield adjacent tissue during electrosurgery. The layer of insulation provides both thermal and electrical insulation.

5 The elongated shaft includes a distal portion, and the first electrode is coupled to the distal portion of the elongated shaft and is side-facing. The shaft includes a bend in the distal portion proximal to the first electrode and includes a distal tip, and the side-facing first electrode is disposed at the distal tip. The elongated shaft defines a longitudinal axis and includes a first side extending longitudinally along the axis. The side-facing first electrode faces toward the first side, and the exposed portion of
10 the second electrode includes a portion facing the first side. A conductor includes the second electrode, and the conductor is disposed around only a portion of the circumference of the elongated shaft. An insulation layer is disposed over at least a portion of the conductor, the insulation layer including a window defining the exposed portion of the second electrode. The conductor includes a clip. A conductive
15 tube is electrically coupled to the first electrode; a first insulation layer is disposed over at least a portion of the conductive tube; and a second insulation layer is disposed over at least a portion of the clip. The first insulation layer and the second insulation layer each include Teflon®.

20 The shaft defines a lumen. The device includes a distal portion and defines a lumen opening at the distal portion, the lumen opening being in communication with the lumen and configured to provide aspiration. A surface area of the exposed portion of the second electrode is at least approximately six times a surface area of the first electrode. The first electrode includes a surface configured to scrape tissue. The first electrode is configured in an ashtray configuration and the surface includes an edge in
25 the ashtray configuration.

The elongated shaft defines a longitudinal axis and includes a distal portion, and the first electrode is coupled to the distal portion of the shaft and is configured to contact tissue straight-on along the longitudinal axis. The elongated shaft includes a distal portion that is malleable to allow a user to bend the shaft. The first electrode is
30 configured to ablate tissue. The entire exposed portion of the second electrode is spaced proximally from the first electrode.

According to another aspect, performing surgery includes applying electrical energy to a first electrode of a bipolar surgical device to perform electrosurgery on a target tissue, the first electrode being disposed on an elongated shaft of the bipolar device. The bipolar device includes a second electrode having an exposed portion
5 disposed around only a part of a circumference of the elongated shaft. Performing surgery also includes providing an insulated surface extending longitudinally along an entire side of the shaft, such that non-target tissue adjacent the insulated surface is shielded during the application of electrical energy to target tissue.

Embodiments of this aspect may include one or more of the following
10 features.

Providing the insulated surface includes providing a thermally and electrically insulated surface. The device includes a bend at a distal portion of the shaft proximal to the first electrode, and providing the insulated surface includes providing a surface extending distally on the shaft only to the bend. Applying electrical energy to
15 perform electrosurgery includes ablating the target tissue. Fluid is aspirated through the shaft. The target tissue is scraped using a surface on the first electrode. The bipolar surgical device is inserted into a body such that the first electrode is adjacent the target tissue. Providing the insulated surface includes using a device that includes a second electrode, the second electrode being coupled to the shaft, electrically
20 isolated from the first electrode, including an exposed portion disposed around only part of a circumference of the elongated shaft, and the exposed portion including a portion that is spaced proximally from the first electrode.

According to another aspect, a surgical device includes an elongated shaft, a first electrode coupled to the shaft, a second electrode coupled to the shaft and
25 including an exposed portion disposed around only part of a circumference of the elongated shaft, and an insulating member coupled to the shaft for providing an insulated surface extending longitudinally along an entire side of the shaft such that non-target tissue adjacent the insulated surface is shielded during the application of electrical energy to target tissue.

Embodiments of this aspect may include one or more of the following features.

5 The mechanism includes a conductor coupled to the shaft and electrically isolated from the first electrode, the conductor disposed around only part of the circumference of the elongated shaft and including a portion configured to serve as a second electrode. The mechanism for providing the insulated surface includes a mechanism for providing a thermally and electrically insulated surface.

10 According to another aspect, a surgical device includes an elongated shaft including a first side; a first electrode coupled to the shaft and side-facing toward the first side, and including an exposed portion that is not disposed around an entire circumference of the elongated shaft; and a second electrode coupled to the shaft, electrically isolated from the first electrode, side-facing toward the first side, and including an exposed portion that is not disposed around an entire circumference of the elongated shaft.

15 Embodiments of this aspect may include the following feature. The side-facing first electrode and the side-facing second electrode face in the same direction on the first side.

20 These and other features will be better appreciated and understood when considered in conjunction with the following description and the accompanying drawings. It should be understood, however, that the following description, while indicating particular implementations and numerous specific details thereof, is given by way of illustration and not of limitation. Many changes and modifications may be made, and such changes and modifications are within the scope of the claims.

25 Brief Description of the Drawings

FIG. 1 is a side view of an electrosurgical device.

FIG. 2 is a perspective view of a distal portion of the electrosurgical device of FIG. 1.

FIG. 3 is a side view of the distal portion shown in FIG. 2.

FIG. 4 is a top view of the distal portion shown in FIG. 2.

FIG. 5 is a cross-sectional view taken along line 5-5 in FIG. 4.

FIG. 6 is a perspective view of a return electrode clip assembly of the
5 electrosurgical device of FIG. 1.

FIG. 7 is a bottom view of the return electrode clip assembly of FIG. 6.

FIG. 8 is a distal end view of the return electrode clip assembly of FIG. 6.

FIG. 9 is a cross-sectional view taken along line 9-9 in FIG. 5.

FIG. 10 is a side view illustrating the use of the electrosurgical device of FIG.
10 1.

FIG. 11 is a longitudinal cross-sectional view of a distal portion of a second
embodiment of an electrosurgical device.

FIG. 12 is a longitudinal cross-sectional view of a distal portion of a third
embodiment of an electrosurgical device.

FIG. 13 is a longitudinal cross-sectional view of a distal portion of a fourth
15 embodiment of an electrosurgical device.

FIG. 14 is a longitudinal cross-sectional view of a distal portion of a fifth
embodiment of an electrosurgical device.

20 Detailed Description

Referring to FIGS. 1 and 2, a surgical device 400 includes an elongated shaft
410, an active electrode 520 coupled to an end 525 of a distal portion 415 of shaft
410, and a return electrode 540 coupled to distal portion 415 of shaft 410 proximal of
active electrode 520 and electrically isolated from active electrode 520. An exposed
25 portion of return electrode 540 is disposed around only part of the circumference of
elongated shaft 410 such that return electrode 540 is on only one side 417 (a top side)

of shaft 410. On an opposite side 419 of shaft 410, there is a thermally and electrically insulated surface (a “cool back”) that acts to shield tissue during electrosurgical use of the device.

Electrosurgical device 400 includes a handle 405 that attaches to a suction tubing 425 and a power cable 430. Power cable 430 carries both active and return power wires to and from an electrosurgical generator (not shown). Power cable 430 has a power connector 435 for attaching cable 430 to a cooperating structure on the electrosurgical generator. Suction tubing 425 has a suction connector 440 for connecting suction tubing 425 to a cooperating standard suction receptacle with a negative aspiration source within an operating room. The amount of suction applied through tubing 425 is controlled by a roller clamp 445 that is applied above suction connector 440. Suction control also can be accomplished, for example, by a series of open ports on handle 405 or a finger activated switch on handle 405.

The assembled length of handle 405 and shaft 410 can be, for example, between 127 to 381 millimeters (“mm”), with the actual length being selected depending on, for example, the size and location of the surgical site. The length of shaft 410 can be, for example, between 76 to 254 mm.

Distal portion 415 has a ninety degree bend 527 such that end 525 and active electrode 520 are side-facing for access to specific anatomies. Different configurations, such as, for example, side-facing configurations having bends of, for example, sixty degrees, forty-five degrees, or thirty degrees, or a configuration having a straight shaft are possible to provide for access to different anatomies within a body.

Active electrode 520 has a concave surface 512 shaped like a shallow dish with an edge 536. In surface 512 there are a sequence of four cutouts 532 providing electrode 520 with an ashtray configuration. Cutouts 532 are formed at four locations along edge 536 spaced approximately ninety degrees apart, have a width that tapers in a radial direction from a maximum at edge 536 to a minimum at approximately half the radial distance to the center of surface 512. Cutouts 532 define additional edges 538 on each side of each cutout 532, and the surface of cutouts 532 is generally concave. A portion 580 of surface 512 (see FIG. 4) lying radially inward from the

minimum width of cutouts 532 can be flat. Edge 536, as well as edges 538, provides for a high focusing of electrical current, that is, a high current density, and cutouts 532 further increase the current density at edge 536. Edge 536, as well as edges 538, also provides a mechanical cutting surface. Cutouts 532 also reduce tissue build-up on electrode 520 during use, which increases the electrosurgical performance of electrode 520.

Active electrode 520 defines an aspiration opening 530 for the removal of fluids and particulate matter from the surgical site near active electrode 520. A non-suction probe also can be constructed by sealing aspiration opening 530 to form a solid active electrode. The decision to use a suction or non-suction probe will depend on the particular surgical site and the procedure to be performed by the physician.

Shaft 410 is largely covered by an outer insulation layer 510 that provides electrical and thermal protection. Return electrode 540 is exposed through a return electrode port 550 in outer insulation layer 510. Return electrode port 550 is cut out of outer insulation layer 510 so that port 550 also is side-facing, in the same direction as end 525 and active electrode 520.

Return electrode 540 is proximally spaced from active electrode 520 along shaft 410. The ratio of the area of the exposed portion of return electrode 540 to the area of active electrode 520 is approximately 8:1 and provides for a higher current density at active electrode 520 than at return electrode 540. The ratio can vary in a range from, for example, 2:1 to 10:1 depending on, for example, the application. Electrode 520 and the exposed portion of return electrode 540 are separated by a distance of about 2.5 mm. In another embodiment, the separation distance can vary in a range from, for example, about 2 mm to 10 mm depending on, for example, the application.

Shaft 410 includes an inner insulation layer 560 that surrounds a periphery 570 of active electrode 520, and extends proximally underneath return electrode 540. Edge 536 of active electrode 520 protrudes past inner insulation layer 560 (see FIG. 3). As a result, two layers of insulation surround distal portion 415 to provide electrical and thermal insulation, as further explained with respect to FIG. 5.

Referring to FIG. 3, RF energy flowing from active electrode 520 is directed to the exposed portion of return electrode 540 through tissue being treated, and thermal energy generated from a RF current path P is primarily concentrated between active electrode 520 and the exposed portion of return electrode 540 on top side 417 and not on bottom side 419 (see FIG. 1). Because the exposed portion of return electrode 540 only extends along a portion of the circumference of shaft 410, a back (or bottom) portion 610 of shaft 410 and any tissue or structure adjacent back portion 610 are shielded from any direct thermal effects caused by RF current path P between active electrode 520 and return electrode 540. Shielding tissue can include, for example, preventing any tissue effect from occurring in the tissue.

Referring to FIG. 4, the exposed portion of return electrode 540 and return electrode port 550 are depicted as having an oval shape, although return electrode port 550 can have a variety of shapes, such as, for example, oval or square, depending on the size of the probe and the configuration of active electrode 520.

Referring to FIG. 5, shaft 410 includes an electrically conductive tube 810 that is physically and electrically coupled to active electrode 520. Tube 810 is, for example, a hypotube shaft of stainless steel or another biocompatible and electrically conductive material such as tungsten, nickel, or any alloys, and the coupling between tube 810 and active electrode 520 is, for example, created by a laser weld. Because tube 810 is conductive, power is transmitted to active electrode 520 through tube 810.

Tube 810 defines an internal suction lumen 820 that communicates with aspiration opening 530 and suction tubing 425 (FIG. 1) for aspiration of fluids and tissue. An inner surface 825 of tube 810 is lined by a suction lining 830 that provides thermal insulation so that tube 810 remains cool despite passage of hot fluids and ablated tissue through lumen 820. Lining 830 can be, for example, an insert or a coating such as a polyolefin or plastic lining that can sustain high temperatures. Device 400 provides an integrated design that is sealed from the surgical environment and is sterile and reliable because fluid ingress does not short out points within device 400.

Inner insulation layer 560 covers tube 810 and provides electrical and thermal insulation to tube 810. Located between inner insulation layer 560 and outer insulation layer 510 is a conductor 840 (see also FIG. 6). The exposed portion of conductor 840, defined by port 550, forms the exposed portion of return electrode 540. Inner insulation layer 560 thus provides electrical insulation between tube 810 and conductor 840. Outer insulation layer 510 contacts inner insulation layer 560 along portions of shaft 410 where inner insulation layer 560 is not covered by conductor 840. Inner insulation layer 560 and/or outer insulation layer 510 can be, for example, a shrink tubing material that is electrically and thermally insulating.

Referring to FIG. 6, conductor 840 includes a conductive clip 910 and a return tab 920. Clip 910 is pre-bent into a cylindrical shape to fit over inner insulation layer 560. Port 550 exposes a portion of clip 910 that defines return electrode 540. Clip 910 can be assembled over inner insulation layer 560 by, for example, sliding clip 910 over inner insulation layer 560. In some implementations, clip 910 is further able to slide between insulation layers 510 and 560 during assembly. Clip 910 also can be assembled, for example, by snapping clip 910 over inner insulation layer 560, with or without the use of a tool to minimize risk of damage of to inner insulation layer 560.

Clip 910 and return tab 920 are formed from a single piece of metal and constitute an integral design, although other implementations need not be integral. In non-integral implementations, clip 910 and tab 920 can be coupled by, for example, crimping, brazing, soldering, welding, or mechanically attaching by using, for example, a spring clip. RF return current flows along tab 920 back to the electrosurgical generator. Return tab 920 is a flat piece of metal, although other implementations can use other structures, such as, for example, a wire. It should be clear that shaft 410 does not include any wires. Further, return tab 920 can be located within an insulated groove located in tube 810 or some other portion of shaft 410. Such a groove can be embedded in shaft 410 such that the cross-sectional profile of shaft 410 remains round.

Clip 910 has edges 930 defining a slot 940 such that clip 910 is not a complete cylinder. Accordingly, when clip 910 is disposed over inner insulation layer 560, clip 910 only extends around a portion of the circumference of shaft 410. In assembly,

clip 910 is positioned on shaft 410 such that slot 940 is on bottom side 419 of shaft 410. In operation, because of the narrow width of return tab 920, the return current path does not generally extend into portions of clip 910 that are not between the portion forming the exposed portion of return electrode 540 and tab 920. As a result of the direction of the return current path, back portion 610 (which can have a circumferential extent larger than that of slot 940) is generally free from any thermal energy generated directly from the return current path. Further, because of the limited circumferential extent of clip 910, any thermal conduction within clip 910 away from the return current path does not extend all the way around bottom side 419 of shaft 410.

Accordingly, back portion 610 is substantially non-thermal and protects non-targeted structures and tissue adjacent back portion 610 from thermal damage. As a result, back portion 610 can be rested against thermally sensitive structures while high temperature treatment, such as, for example, cutting or ablation occurs at active electrode 520 on the opposite side of shaft 410. The thermal protection results in a safer application of RF energy.

Referring to FIG. 7, clip 910 has a length L1 of, for example, approximately 50 mm, and return tab 920 has a width L2 of, for example, approximately 5 mm. These dimensions are not critical to operation and can vary depending on, for example, the size of the exposed portion of the return electrode and the amount of current. For example, in one application, L1 can vary from about 10 mm to the full length of the shaft, and L2 can vary from about 1 mm to the full circumference of the shaft.

Referring to FIG. 8, clip 910 is about three-fourths of a complete cylinder, that is, slot 940 extends over an arc α of about ninety degrees. These sizes are not critical and can vary depending on, for example, the location of the tissue undergoing surgery. For example, in one application, α can vary from about 0 degrees to 270 degrees.

Referring to FIG. 9, inner insulation layer 560 insulates tube 810 from conductor 840, preventing shorting between tube 810 and conductor 840. A dual

layer of insulation is formed from outer insulation layer 510 and inner insulation layer 560 on that part of back portion 610 of device 400 where clip 910 does not encircle outer insulation layer 560. This provides an electrically and thermally insulated "cool back" where minimal electrical and thermal effects occur. As explained earlier, a cool
5 back also can extend to portions of back portion 610 that overlap clip 910 but that do not have any appreciable thermal heating. With such an arrangement, device 400 can be placed and used within a narrow joint space and against thermally sensitive tissue, and such thermally sensitive, non-targeted tissue located opposite active electrode 520 and the exposed portion of return electrode 540 is protected from thermal injury.

10 The double insulation also has the advantage of protecting against shorting from peeling back which is common with high energy and high heat electrosurgical probes. "Peeling back" refers to a situation in which a part of the insulation at the distal portion peels back and can thereby expose underlying conductive material. With two layers of insulation 560 and 510, shorting does not occur unless both layers
15 560 and 510 peel back or are otherwise compromised.

Port 550 is defined in outer insulation layer 510 to extend more than 180 degrees about the circumference of layer 510, for example, 210 degrees. Port 550 can extend circumferentially over various angles depending on, for example, the desired surface area of the exposed portion of return electrode 540.

20 Referring to FIG. 10, in use to treat body tissue 1310, edges 536 of active electrode 520 physically contact tissue at a tissue treatment site 1320, providing mechanical and electrical treatment effects. As a surgeon applies power to active electrode 520, RF current flows from active electrode 520 through tissue 1320 along RF current flux lines 1330. If the exposed portion of return electrode 540 is large,
25 then the exposed portion of return electrode 540 can contact tissue, without affecting the tissue.

During application of energy, tissue fragments 1340 and bubbles 1350 created by the high temperatures generated by the RF energy in saline become free floating near device 400. These fragments 1340 and bubbles 1350 can be removed from the

surgical site through aspiration opening 530 and suction lumen 820. Alternatively, a separate suction probe can be used.

Active electrode 520 can have different configurations to contact tissue. Edges 536 can be formed for various scraping applications for mechanical tissue treatment or removal, in addition to electrosurgical applications. Active electrode 520 can be molded or pressed to form any shape that can mechanically affect tissue. Examples of electrode configurations include, for example, a clover leaf and a cross fire, as depicted in U.S. Patent Number 6,461,357. Other insulating structure, such as, for example, an insulating collar can be used to further insulate active electrode 520 from return electrode 540. Return electrode 540 can be formed from a portion of tube 810, using proper insulating regions on tube 810 to electrically isolate the two electrodes 520 and 540.

Referring to FIG. 11, rather than being bent at the distal portion, electrosurgical device 1500 has a forward-facing active electrode 520. Device 1500 is otherwise as described above with reference to device 400. Device 1500 can be used, for example, for precise hemostatic cutting and ablation of soft tissue in one convenient device which can be described as a chisel.

Referring to FIG. 12, an electrosurgical device 1600 shown with a forward-facing active electrode 520 includes an active electrode mesh 1610 covering active electrode 520 and a return electrode mesh 1620 covering the exposed portion of return electrode 540. Meshes 1610 and 1620 are conductive and lie in contact with active electrode 520 and return electrode 540, respectively. Meshes 1610 and 1620 thus form part of active electrode 520 and the exposed portion of return electrode 540, respectively. The use of a mesh provides additional edges (wire conductors) for electrosurgical applications and mechanical scraping, as well as providing additional surface area. Meshes 1610 and 1620 can be disposed over an insulator, in which case meshes 1610 and 1620 constitute the entirety of active electrode 520 and return electrode 540, respectively. Meshes can be used over or in place of the electrodes in the side-facing embodiment of FIG. 1. Meshes, screens, or wire electrodes, for example, having different configurations also can be used depending on, for example, the application and desired electrode characteristics.

The configuration of the probe shaft allows the surgeon to have better access and more selective control while in the operating environment. For example, the electrosurgical probe of FIG. 4 is particularly suitable for use in an arthroscopic acromioplasty wherein the coracoacromial ligament is cut and associated tendons are removed. The right angle of the energy application tip allows the surgeon to scrape target tissue from the underside of the acromion. Various other configurations and geometries of the energy application tip, as shown, for example, in FIGS. 11 and 12, allow the surgeon to perform a variety of arthroscopic procedures to access various joint geometries within the body.

Referring to FIG. 13, a shaft 1710 is an alternate implementation of shaft 410. Shaft 1710 has a diameter at a distal portion 1712 that is smaller than the diameter of shaft 410 at distal portion 415. Accordingly, shaft 1710 is advantageously used to perform surgery in small operating environments such as small joint applications, as discussed below. Shaft 1710 mates with handle 405, however, just as shaft 410 does, and so shaft 1710 has a diameter equal to that of shaft 410 at a location 1770 where shaft 1710 mates with handle 405. Shaft 1710 achieves the smaller diameter at distal portion 1712 by stepping down the diameter of shaft 1710 from a maximum at handle 405 to a minimum at distal portion 1712. The step down in diameter is achieved by using three concentric tubes 1765, 1755, and 1715 of decreasing diameter as explained below.

Shaft 1710 includes conductive inner tube 1715 defining a lumen 1720, an inner suction lining 1725, an inner insulation layer 1730, a conductor 1735 that forms a return electrode 1740, and an outer insulation layer 1745 with a cutout 1750 defining an exposed portion of return electrode 1740.

Shaft 1710 also includes conductive middle tube 1755 that is concentric with inner tube 1715. Tubes 1715 and 1755 are crimped together at a location 1760 to secure inner tube 1715 to middle tube 1755. Shaft 1710 further includes conductive outer tube 1765 that is concentric with, and crimped to, both inner tube 1715 and middle tube 1755 at location 1770 to secure outer tube 1765 to both middle tube 1755 and inner tube 1715. Outer tube 1765 has the same diameter as tube 810 of FIG. 5, and handle 405 receives and mates with outer tube 1765 in a manner similar to the

manner is in which handle 405 receives and mates with tube 810. Inner tube 1715, middle tube 1755, and outer tube 1765 can each be, for example, a hypotube. Tubes 1755 and 1765 need not be conductive, however. The crimping can be performed, for example, using a four-point crimp.

5 Attached to a distal end 1780 of shaft 1710 is a dome-shaped active electrode 1790 defining an aspiration opening 1792 in communication with lumen 1720. Electrode 1790 includes a cylindrical side wall 1794 defining a bore 1796 that receives inner tube 1715. Inner tube 1715 is laser welded near a bottom portion 1798 of side wall 1794, and typically on the outside of side wall 1794. Insulation layers
10 1730 and 1745 are positioned on the outside of side wall 1794. Electrode 1790 receives electrical power from a generator through inner tube 1715 for performing ablation or other electrosurgical procedures.

As explained above, shaft 1710 is advantageously used to perform surgery in small operating environments. Shaft 1710 has a diameter “d” at distal end 1780 of
15 approximately 2 mm and a length “L” of approximately 100 mm. These values can be compared to typical value of approximately 3.5 mm and 150 mm for the implementation shown in FIG. 5. Accordingly, handle 405 is used with devices having electrodes of various sizes and intended to be used in various locations of a body. Shaft 1710 may be preferred by a surgeon for performing electrosurgery on, for
20 example, a wrist, whereas the implementation of FIG. 5 may be preferred by a surgeon for performing electrosurgery on a knee.

Middle tube 1755 typically extends only part of the distance (L) between handle 405 and electrode 1790. The length of this extension affects, for example, the flexibility and rigidity of shaft 1710 and can vary depending on, for example, the
25 application and a surgeon’s preference. In particular embodiments, middle tube extends, for example, approximately one-third or two-thirds of the distance L.

Aspiration opening 1792 is electrically conductive and can electrically affect (for example, ablate) tissue lodged within aspiration opening 1792, thus inhibiting clogging of aspiration opening 1792. Further, aspiration opening 1792 has a diameter

that is less than the diameter of lumen 1720 to inhibit clogging of lumen 1720.

Device 400 of FIG. 1 enjoys the same characteristics.

Referring to FIG. 14, electrosurgical device 1900 includes a dome-shaped active electrode 1910 that does not have an aspiration opening. Active electrode 1910
5 is coupled to a tube 1915 by a laser weld near a bottom portion 1920 of electrode 1910. Tube 1915 is solid, although a hollow tube can be used as well.

Electrosurgical devices can be malleable or pre-bent to allow for appropriate access and control within the surgical environment. Malleable probe tips, particularly solid probe tips, such as, for example, tube 1915, can be configured by the surgeon or
10 other user as straight, angled, or curved, for example, to provide for optimal access to specific anatomy and pathology. The described tip designs provide tactile feedback from, for example, the edges or other scraping surfaces, and provide for improved tissue visualization by, for example, reducing bubbling and/or charring.

As discussed above, return electrode port 550 is cut out of outer insulation
15 layer 510 so that port 550 also is side-facing, in the same direction as end 525 and active electrode 520. Exposed portions of active and return electrodes can be side-facing in the same direction, as in device 400, or alternatively, the exposed portions of the electrodes can be side-facing in directions that are different. Exposed portions of electrodes that are side-facing in different directions can be circumferentially
20 separated by an angle that is, for example, quite small, such that exposed portions of both electrodes are facing in generally the same direction or at least facing toward the same side of the shaft (for example, the top side 417). Further, for exposed portions of electrodes that, taken as a whole, are facing different directions, there can be portions on each electrode that face the same direction. It should be clear that various
25 configurations in which the exposed portions of the electrodes, taken as a whole, are not facing in the same direction can still provide a cool back.

Materials for the active and return electrodes include, for example, titanium, tungsten, platinum, or nickel based alloys. Other biocompatible metals and alloys generally used in sterile electrosurgical devices also can be used for the electrodes.
30 The shaft of device 400 can be, for example, stainless steel, titanium, platinum, or

tungsten and the handle can be made of, for example, Acrylonitrile Butadiene Styrene (“ABS”) plastic or other compatible materials.

The various tubes described can have other shapes besides cylindrical, such as, for example, oval and rectangular, and can have a diameter or other size that varies with distal location, such as, for example, that provided in a tapering cylindrical tube. Various other configurations are also possible. For example, an insulative tube can be used as an “inner insulation layer” with an inner conductive coating (or a partial coating, such as, for example, a strip) serving as the mechanism for coupling RF power to an active electrode, and an outer conductive coating (or strip, for example) serving as a return electrode (for example, return electrode 540) and/or a return conductor (for example, return tab 920). Other variations also are contemplated, such as, for example, an insulative tube serving as the “lumen lining” with conductive and insulative coatings, for example, applied to the outer surface of the insulative tube.

Inner insulation layer 560 or outer insulation layer 510 can be, for example, a polytetrafluoroethylene (“PTFE”) material and also can include polyamide, plastic, or polyolefin which provide for electrical isolation. Layers 510 and/or 560 can be made from heat shrink tubing including such materials, and heat shrink tubing allows for a quick and easy manufacturing process along with durability and simplified sterilization requirements. In one implementation, device 400 is designed for a single use and is discarded after a single operation.

The power delivered by device 400 is, for example, up to 200 watts. Typical operational power is, for example, 120 watts for ablation and 50 watts for coagulation. For the device of FIG. 13, typical operational power is, for example, 80 watts for ablation and 40 watts for coagulation. The maximum output voltage of the generator powering the devices is, for example, 320 V rms which corresponds to a peak-to-peak voltage of approximately 1000 V. The output frequency of the generator is, for example, 460 kHz sinusoidal, and the output can be unmodulated, that is, have a duty cycle of 100%. RF power can be controlled using, for example, a foot pedal. RF controls also can be provided in handle 405.

To maintain the appropriate temperature for cutting tissue, the distal portion of the probe also can be equipped with a thermal feedback system such as a thermocouple. In one implementation, the thermocouple is connected to two leads and is placed between the active electrode and the exposed portion of the return electrode in order to provide feedback of the actual tip temperature. Other types of temperature feedback circuits can be used. Specific examples include thermistors and thermal integrated circuits. Such temperature feedback circuits return probe temperature information to the generator in order to modulate power, thus changing the energy output and the temperature.

It also will be appreciated that the active electrode can be, for example, brazed, crimped, soldered, welded, or mechanically attached. Further, the active and return electrodes can include, for example, titanium, tungsten, and their alloys, or stainless steel, and the return tab can include, for example, stainless steel in a variety of tensile strengths, titanium, copper, or any suitable alloys thereof.

In particular implementations described, the active electrode generates heat by concentrating RF energy at sharp edges causing, for example, cutting and ablation while the return electrode generates little heat due to the larger ratio of exposed surface area and lack of sharp edges. These distal energy application tips and active electrode designs also can be used in conventional monopolar surgical systems where the return electrode is located on the patient's body.

An example involves a probe being used in the knee joint during a notchplasty procedure for anterior cruciate ligament repair. The probe configuration, in particular the energy application tip configuration, is used to remove and scrape the condylar surfaces of a femur to increase the interchondylar notch to free the anterior cruciate ligament from impingement. The anterior cruciate ligament also can be cut and removed using the probe, and a patellar tendon graft can be performed.

The foregoing description has been presented for purposes of illustration and description. It is not intended to be exhaustive or to limit the claims to the precise forms disclosed. Modifications and variations will be apparent to practitioners skilled in this art. For example, with respect to the disclosed implementations, as well as

other implementations, monopolar implementations can be achieved by using a second probe that is independently coupled to the electrosurgical generator, or alternatively, simply by providing an additional electrode as a return electrode on the body of a patient and not activating the return electrode on the probe. These and
5 various other modifications can be made to the disclosed implementations. It is intended that the scope of the invention be defined by the following claims and their equivalents.

WHAT IS CLAIMED IS:

1. A surgical device comprising:
an elongated shaft;
a first electrode coupled to the shaft; and
5 a second electrode coupled to the shaft, electrically isolated from the first electrode, the second electrode including an exposed portion disposed around only part of a circumference of the elongated shaft, and including a portion that is spaced proximally from the first electrode.
2. The surgical device of claim 1 further comprising:
10 a conductor that includes the second electrode, the conductor being disposed around only a portion of the circumference of the elongated shaft; and
a layer of insulation disposed over at least a portion of the conductor and including a window that defines the exposed portion of the second electrode, the layer of insulation also being disposed over at least a designated part of the elongated shaft
15 around which the conductor is not disposed, wherein the designated part provides an insulated area that is configured to shield adjacent tissue during electrosurgery.
3. The surgical device of claim 2 wherein the layer of insulation provides both thermal and electrical insulation.
- 20 4. The surgical device of claim 1 wherein:
the elongated shaft comprises a distal portion, and
the first electrode is coupled to the distal portion of the elongated shaft and is side-facing.

5. The surgical device of claim 4 wherein
- the elongated shaft defines a longitudinal axis and comprises a first side extending longitudinally along the axis,
- the side-facing first electrode faces toward the first side, and
- 5 the exposed portion of the second electrode includes a portion facing the first side.
6. The surgical device of claim 5 further comprising:
- a conductor that includes the second electrode, the conductor being disposed around only a portion of the circumference of the elongated shaft; and
- 10 an insulation layer disposed over at least a portion of the conductor, the insulation layer including a window defining the exposed portion of the second electrode.
7. The surgical device of claim 6 wherein the conductor comprises a clip.
8. The surgical device of claim 7 further comprising:
- 15 a conductive tube that is electrically coupled to the first electrode;
- a first insulation layer disposed over at least a portion of the conductive tube;
- and
- a second insulation layer disposed over at least a portion of the clip.

9. The surgical device of claim 8 wherein the first insulation layer and the second insulation layer each comprise Teflon®.

10. The surgical device of claim 1 wherein:

the shaft defines a lumen, and

5 the device comprises a distal portion and defines a lumen opening at the distal portion, the lumen opening being in communication with the lumen and configured to provide aspiration.

11. The surgical device of claim 1 wherein a surface area of the exposed portion of the second electrode is at least approximately six times a surface area of the
10 first electrode.

12. The surgical device of claim 1 wherein the first electrode comprises a surface configured to scrape tissue.

13. The surgical device of claim 12 wherein the first electrode is configured in an ashtray configuration and the surface comprises an edge in the
15 ashtray configuration.

14. The surgical device of claim 1 wherein:

the elongated shaft defines a longitudinal axis and comprises a distal portion,
and

the first electrode is coupled to the distal portion of the shaft and is configured
20 to contact tissue straight-on along the longitudinal axis.

15. The surgical device of claim 1 wherein the elongated shaft comprises a distal portion that is malleable to allow a user to bend the shaft.

16. The surgical device of claim 1 wherein the first electrode is configured to ablate tissue.

5 17. The surgical device of claim 1 wherein the entire exposed portion of the second electrode is spaced proximally from the first electrode.

18. The surgical device of claim 4 wherein:

the shaft includes a bend in the distal portion proximal to the first electrode and includes a distal tip, and

10 the side-facing first electrode is disposed at the distal tip.

19. A method of performing surgery, the method comprising:

applying electrical energy to a first electrode of a bipolar surgical device to perform electrosurgery on a target tissue, the first electrode being disposed on an elongated shaft of the bipolar device, the bipolar device further including a second
15 electrode having an exposed portion disposed around only a part of a circumference of the elongated shaft; and

providing an insulated surface extending longitudinally along an entire side of the shaft, such that non-target tissue adjacent the insulated surface is shielded during the application of electrical energy to target tissue.

20. The method of claim 19 wherein providing the insulated surface comprises providing a thermally and electrically insulated surface.

21. The method of claim 19 wherein:

the device includes a bend at a distal portion of the shaft proximal to the first
5 electrode, and

providing the insulated surface comprises providing a surface extending distally on the shaft only to the bend.

22. The method of claim 19 wherein applying electrical energy to perform electrosurgery comprises ablating the target tissue.

10 23. The method of claim 19 further comprising aspirating fluid through the shaft.

24. The method of claim 19 further comprising scraping the target tissue using a surface on the first electrode.

15 25. The method of claim 19 further comprising inserting the bipolar surgical device into a body such that the first electrode is adjacent the target tissue.

26. The method of claim 19 wherein providing the insulated surface comprises using a device that includes a second electrode, the second electrode being coupled to the shaft, electrically isolated from the first electrode, including an exposed portion disposed around only part of a circumference of the elongated shaft, and the
20 exposed portion including a portion that is spaced proximally from the first electrode.

27. A surgical device comprising:

an elongated shaft;

a first electrode coupled to the shaft;

5 a second electrode coupled to the shaft and including an exposed portion disposed around only part of a circumference of the elongated shaft; and

means coupled to the shaft for providing an insulated surface extending longitudinally along an entire side of the shaft, such that non-target tissue adjacent the insulated surface is shielded during the application of electrical energy to target tissue.

28. The surgical device of claim 27 wherein the means comprises a
10 conductor coupled to the shaft and electrically isolated from the first electrode, the conductor disposed around only part of the circumference of the elongated shaft and including a portion configured to serve as a second electrode.

29. The surgical device of claim 27 wherein the means for providing the insulated surface comprises means for providing a thermally and electrically insulated
15 surface.

30. A surgical device comprising:

an elongated shaft including a first side;

a first electrode coupled to the shaft and side-facing toward the first side, and including an exposed portion that is not disposed around an entire circumference of
20 the elongated shaft; and

a second electrode coupled to the shaft, electrically isolated from the first electrode, side-facing toward the first side, and including an exposed portion that is not disposed around an entire circumference of the elongated shaft.

31. The surgical device of claim 30 wherein the side-facing first electrode
5 and the side-facing second electrode face in the same direction on the first side.

400

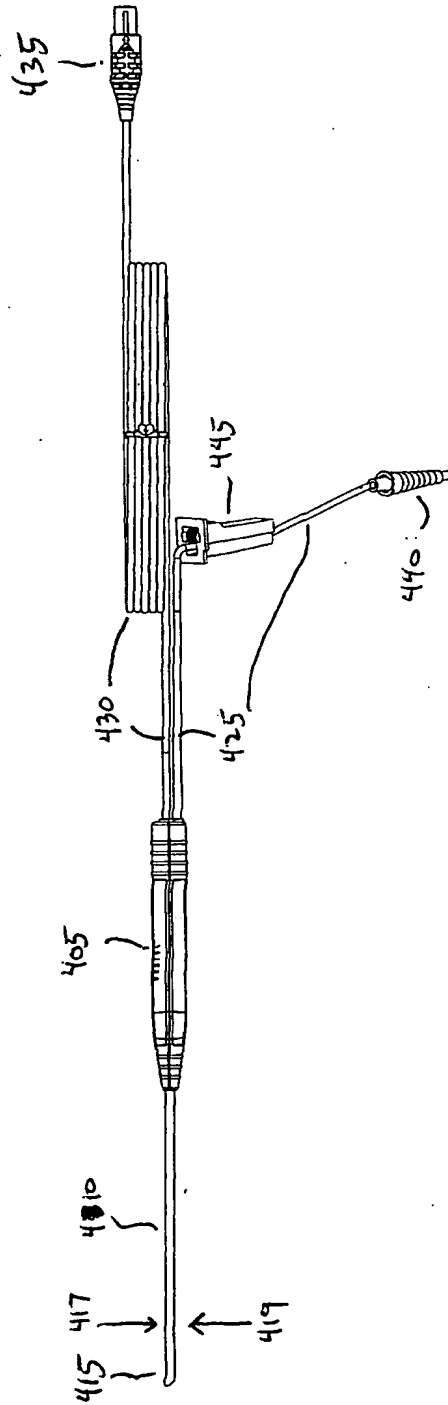
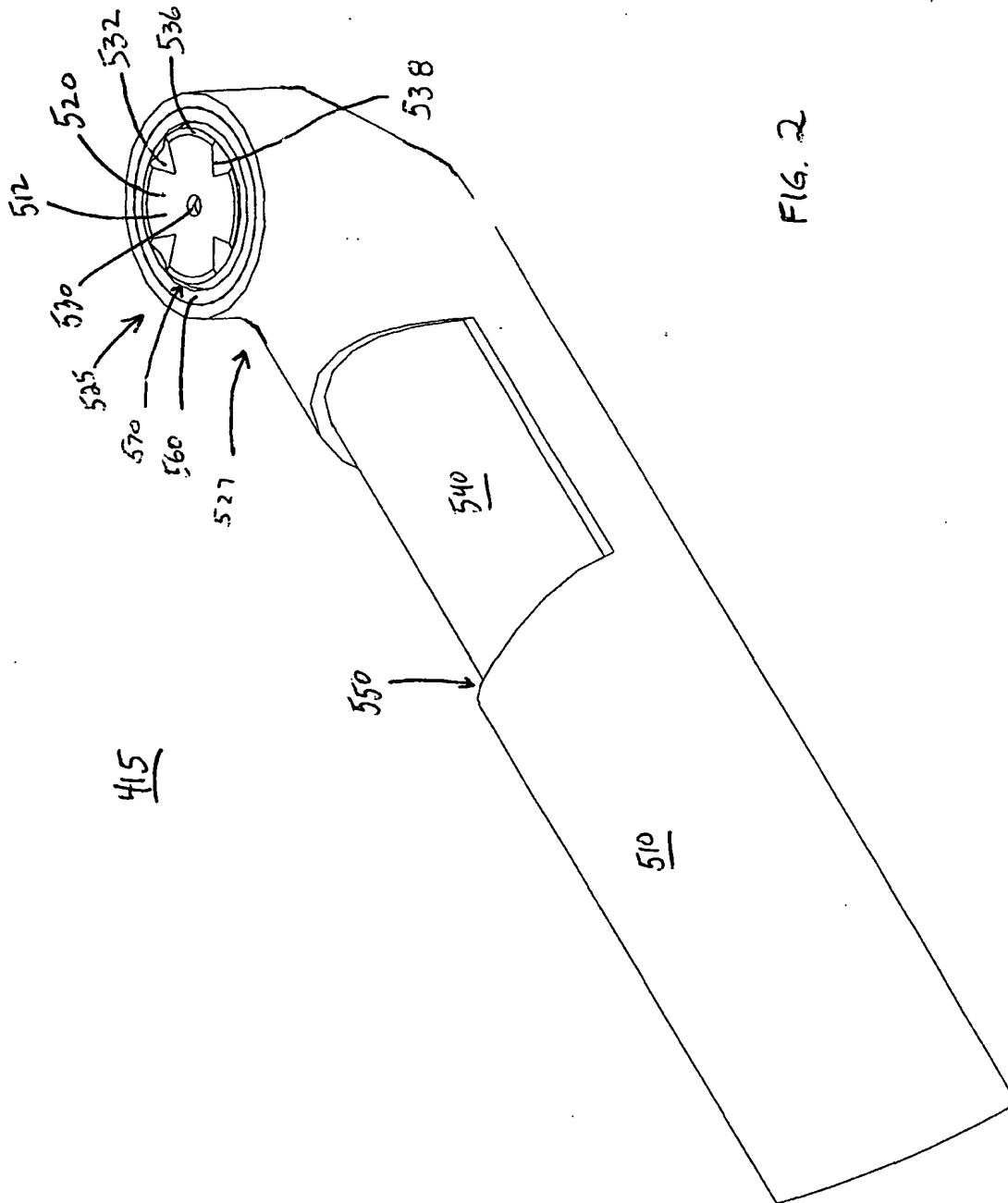
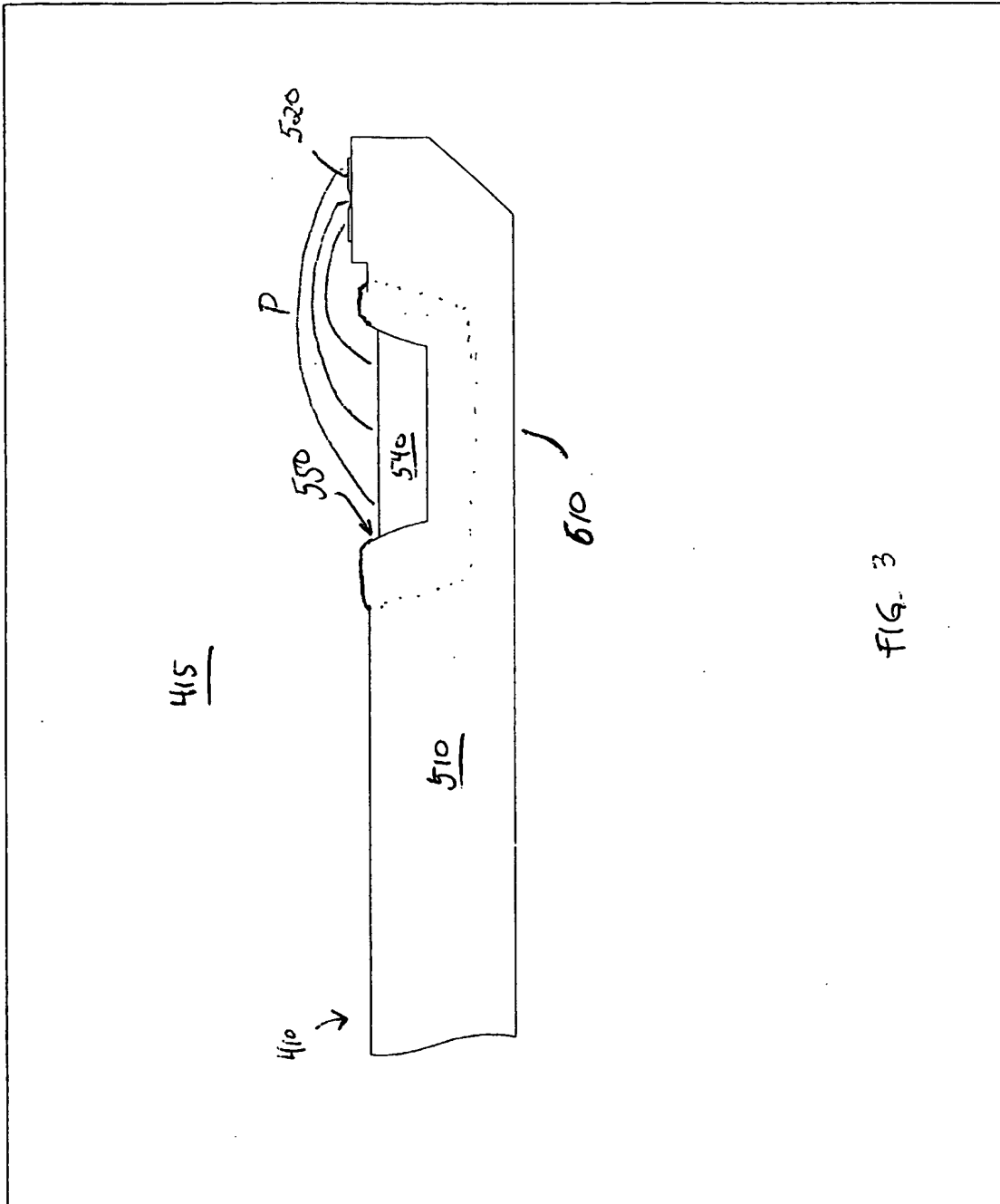


FIG. 1





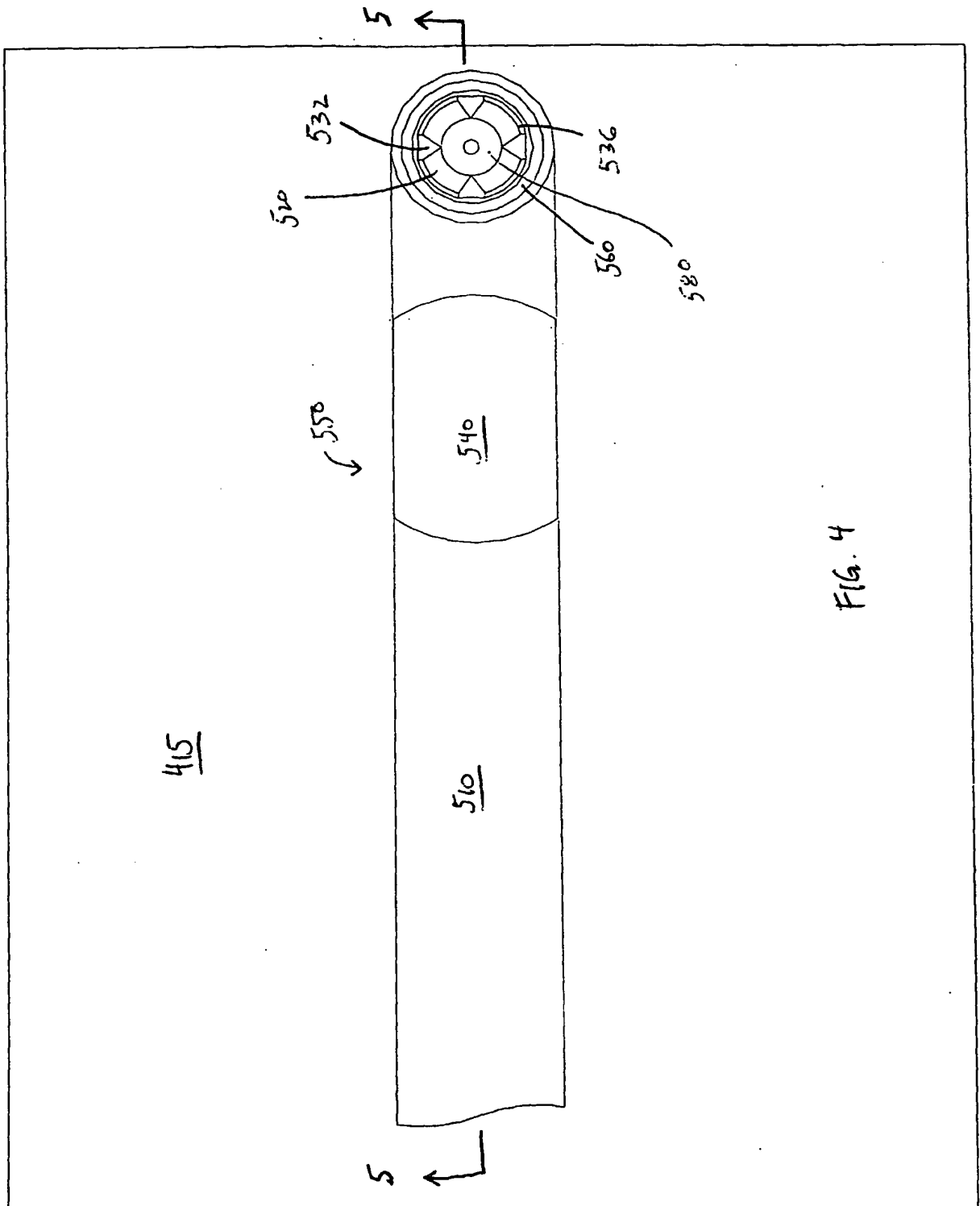
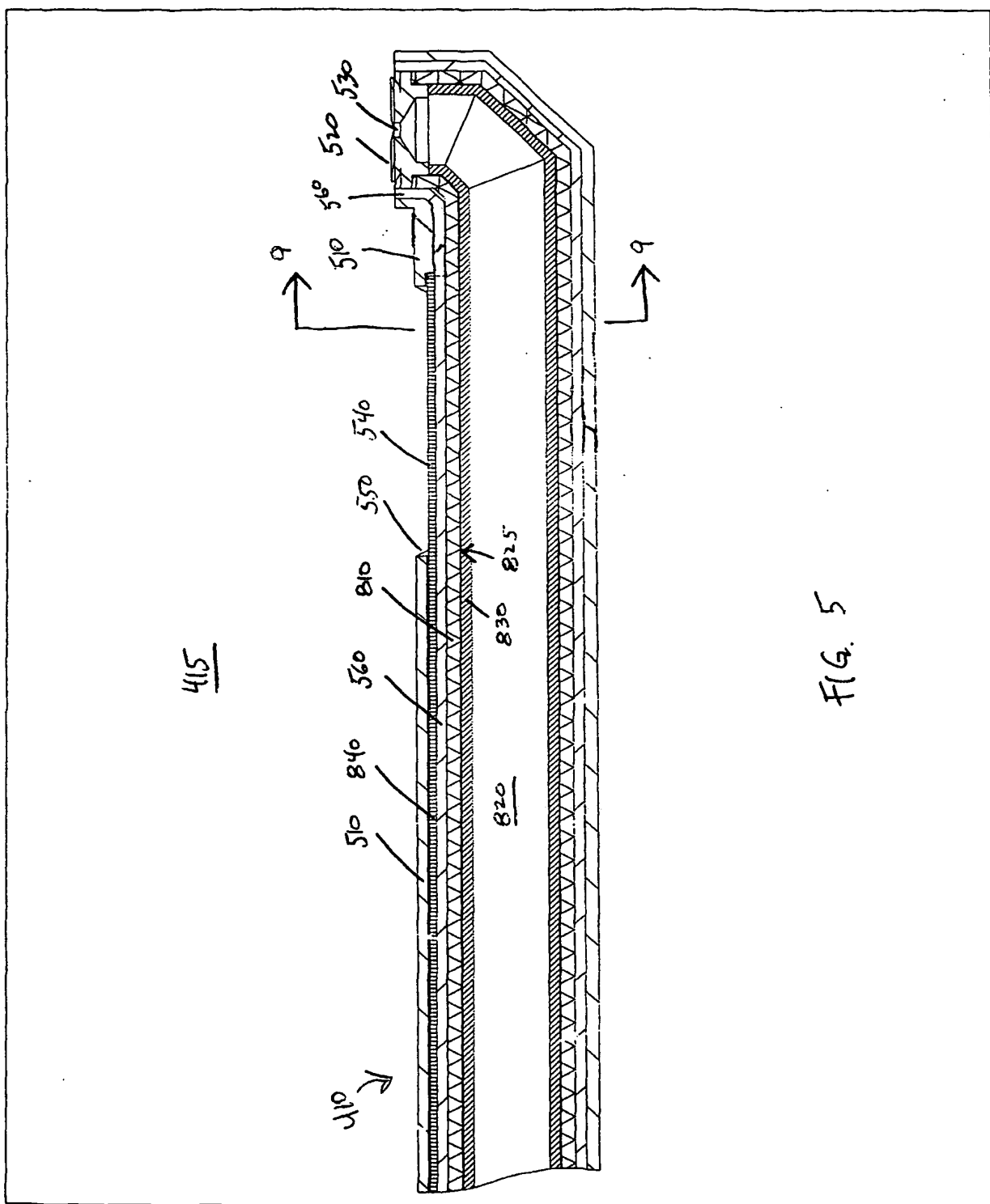
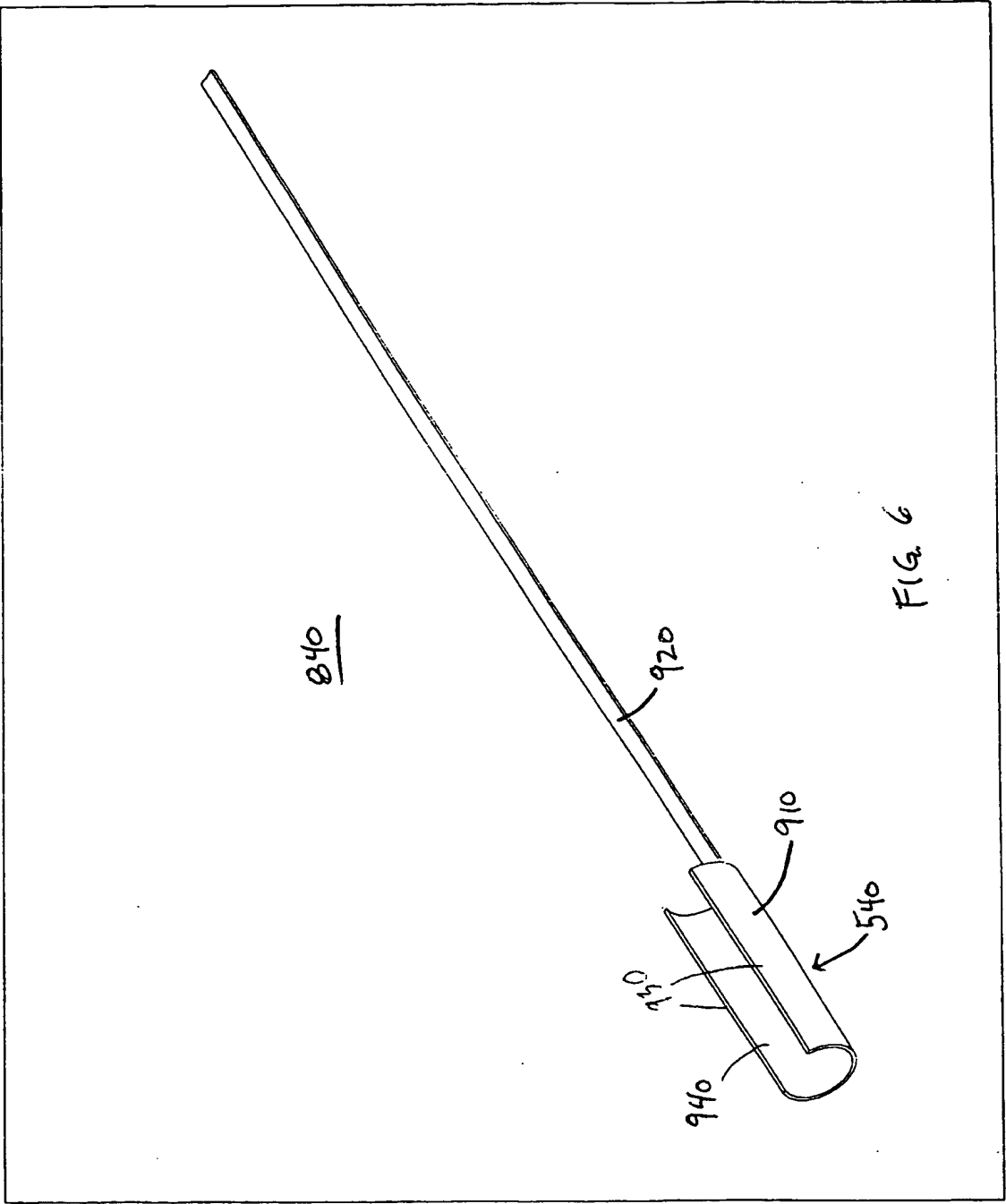
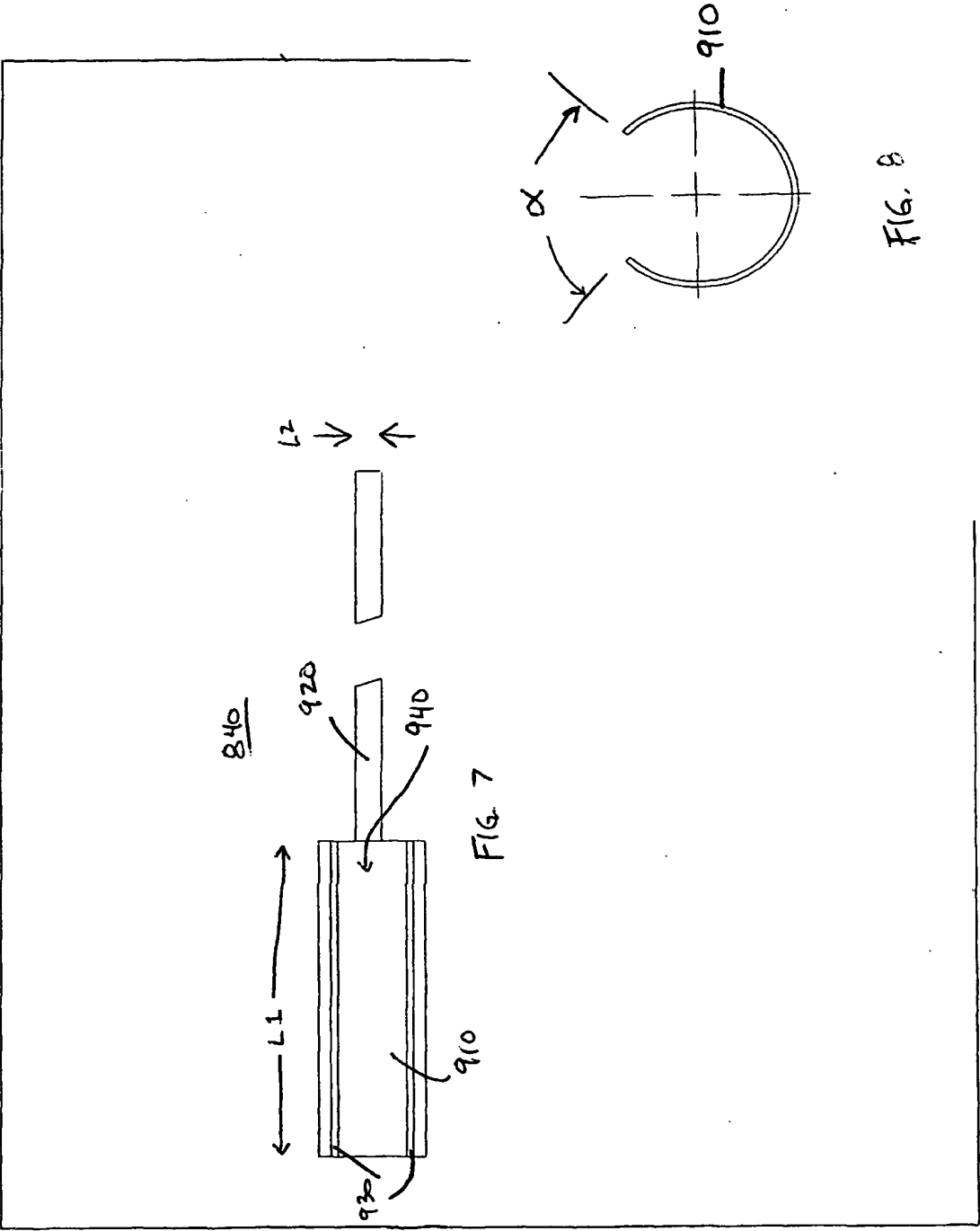


Fig. 4







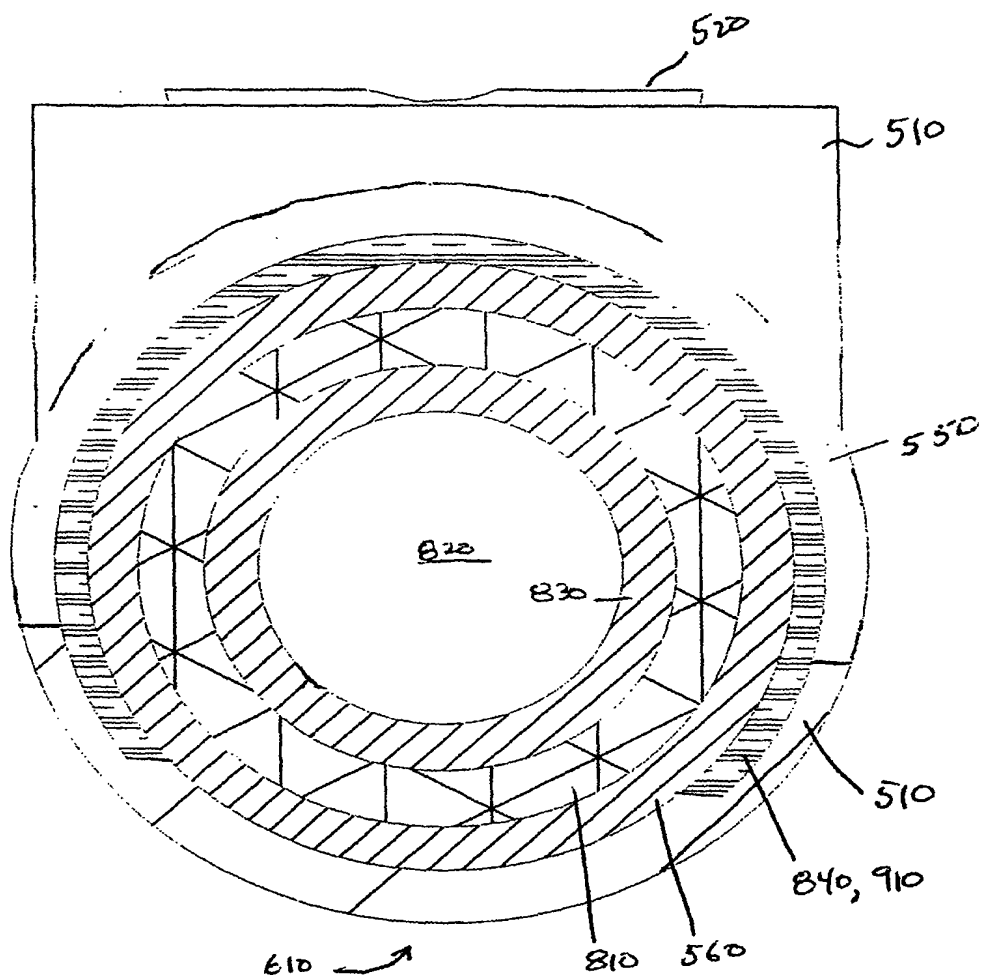
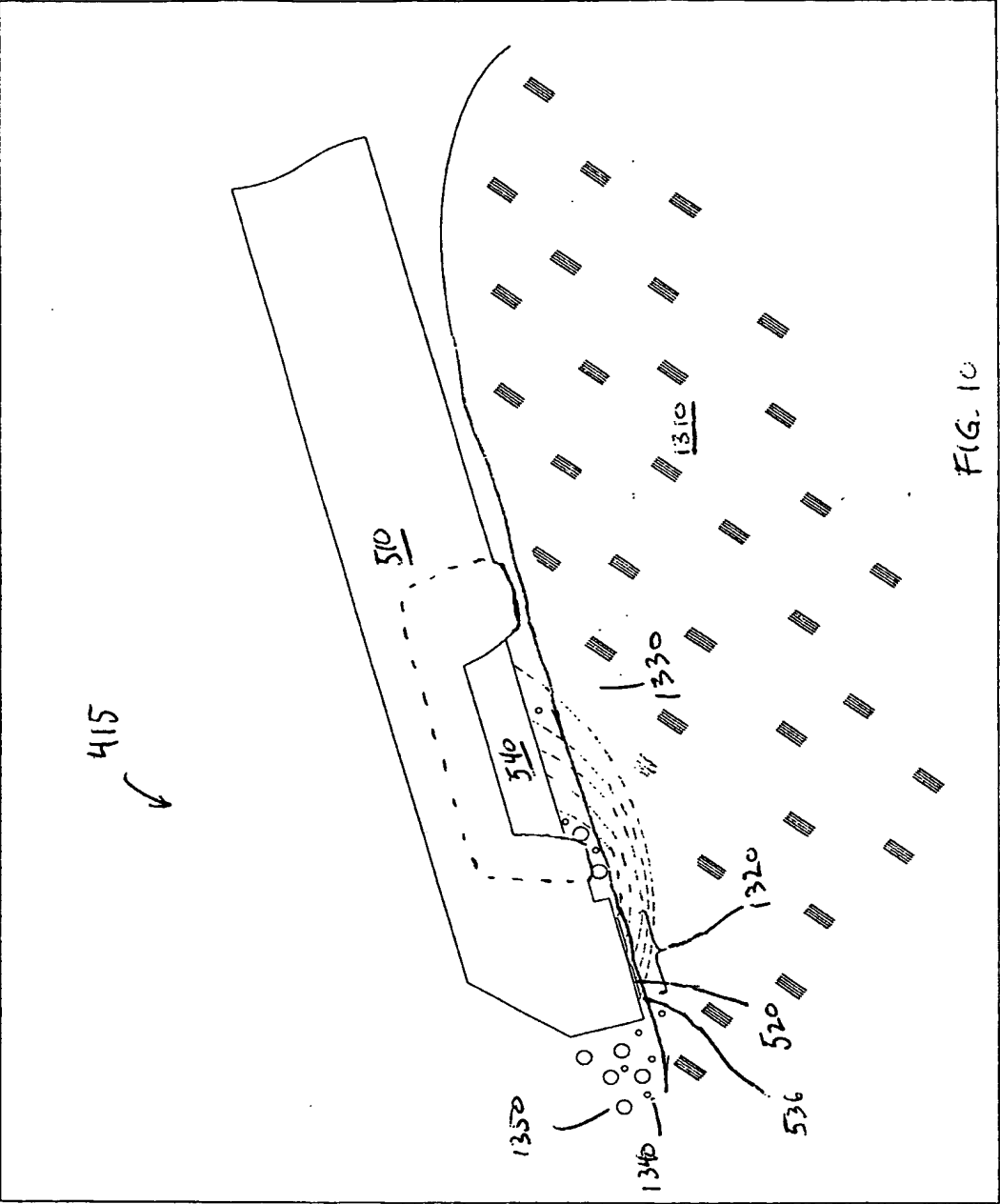


FIG. 9



1500

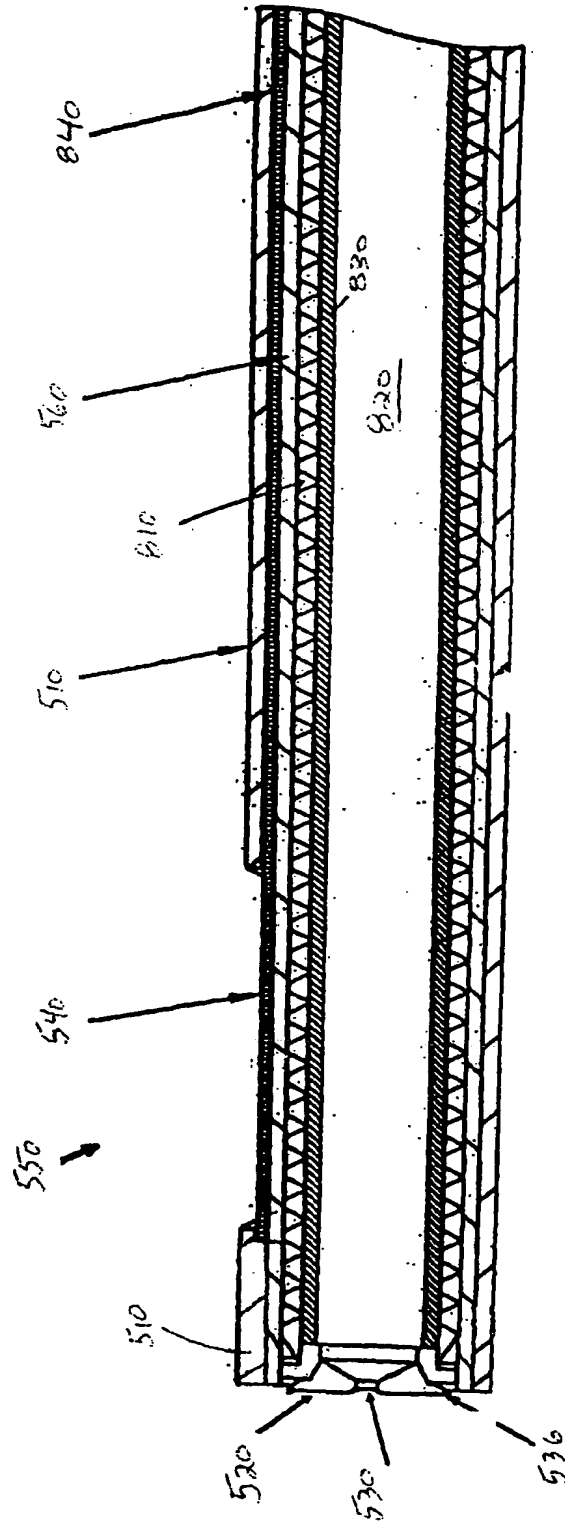


FIG. 11

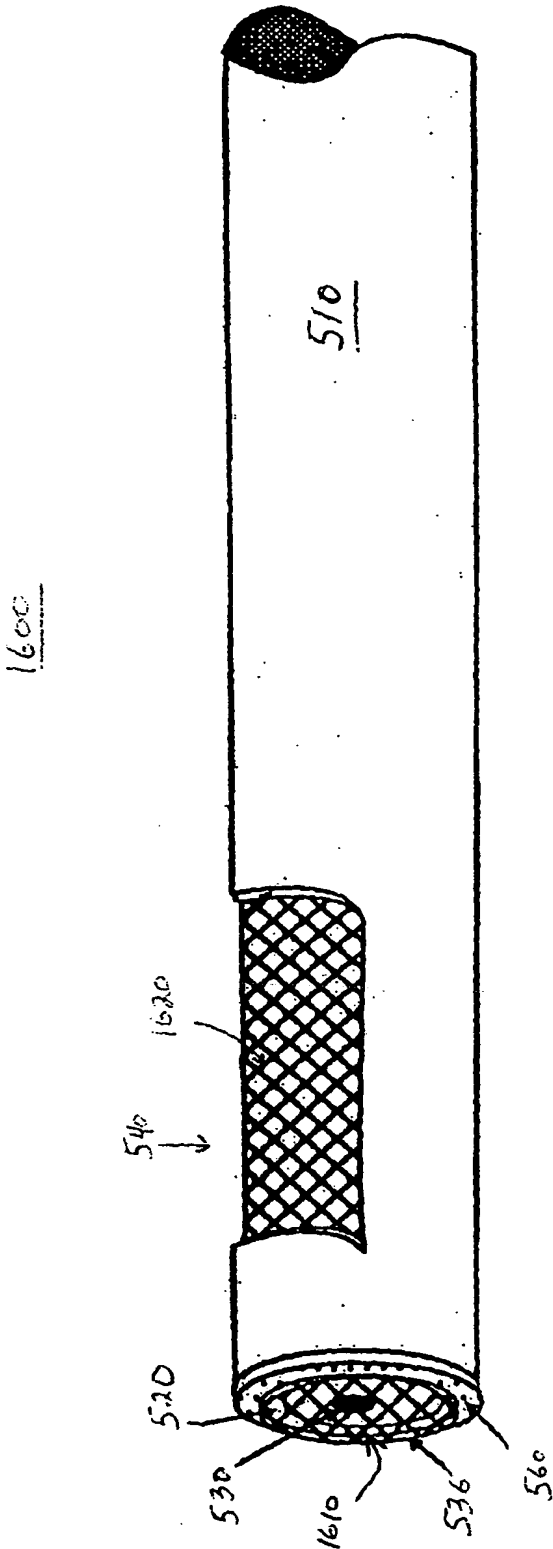


FIG. 12

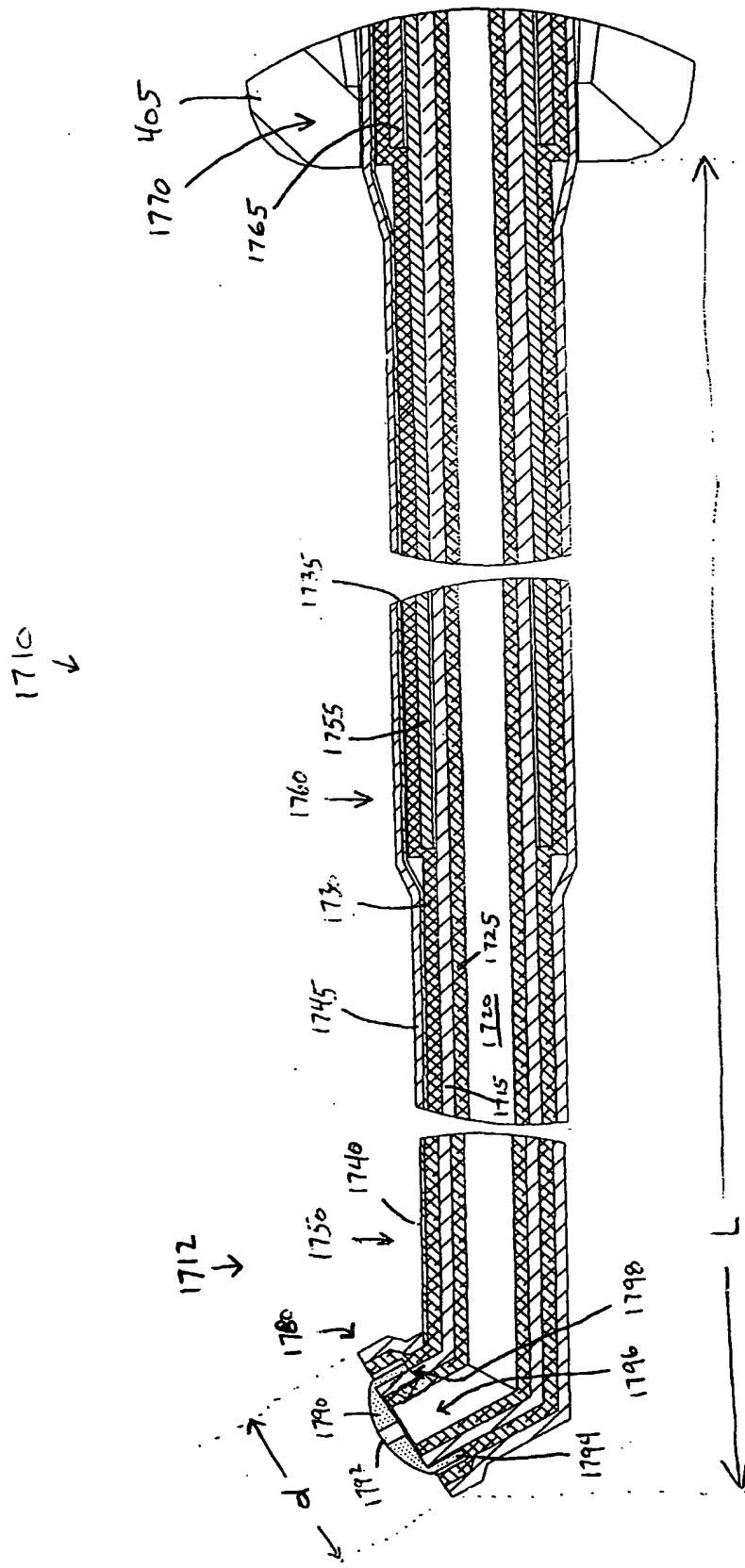


FIG. 13

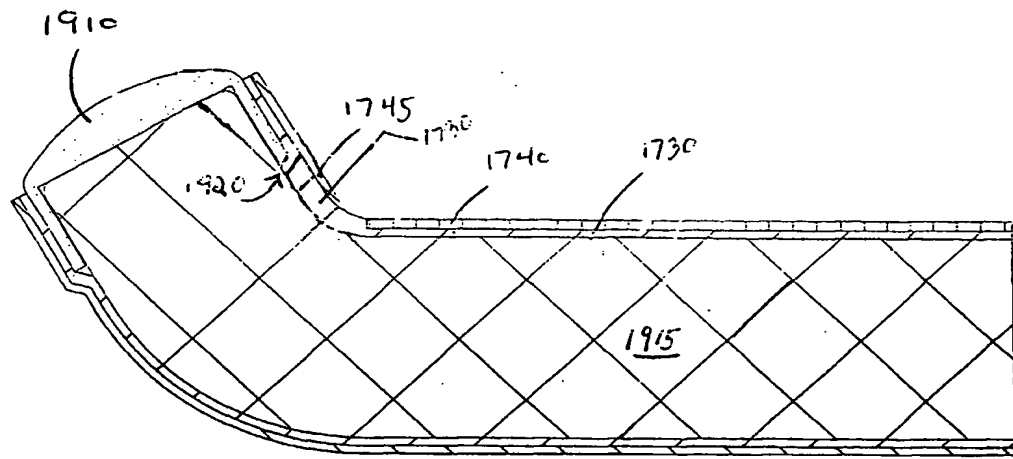


FIG. 14

1900

INTERNATIONAL SEARCH REPORT

Int. Application No

PC 03/04139

A. CLASSIFICATION OF SUBJECT MATTER
IPC 7 A61B18/14

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

IPC 7 A61B

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

EPO-Internal

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	WO 92 21278 A (EP TECHNOLOGIES) 10 December 1992 (1992-12-10)	1,2,27
A	page 11, line 21-27, paragraph 3; figures 1,2	30
X	WO 99 48430 A (GYRUS MEDICAL LTD ;GOBLE COLIN CHARLES OWEN (GB); GOBLE NIGEL MARK) 30 September 1999 (1999-09-30)	1,4,27
X	US 5 626 576 A (JANSSEN MICHAEL) 6 May 1997 (1997-05-06)	1,27
A	column 5, line 34-37; figure 7	30
A	WO 95 13027 A (BIRTCHE MED SYST ;FLEENOR RICHARD P (US); BROMLEY ROBERT L (US)) 18 May 1995 (1995-05-18)	1,27,30
	page 17, paragraph 2; figure 7	

☐ Further documents are listed in the continuation of box C.

☒ Patent family members are listed in annex.

* Special categories of cited documents :

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Date of the actual completion of the international search

9 May 2003

Date of mailing of the international search report

20/05/2003

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Papone, F

INTERNATIONAL SEARCH REPORT

International application No.
PCT/US 03/04139

Box I Observations where certain claims were found unsearchable (Continuation of Item 1 of first sheet)

This International Search Report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

1. ☒ Claims Nos.: 19-26
because they relate to subject matter not required to be searched by this Authority, namely:
Rule 39.1(iv) PCT - Method for treatment of the human or animal body by surgery
2. ☐ Claims Nos.:
because they relate to parts of the International Application that do not comply with the prescribed requirements to such an extent that no meaningful International Search can be carried out, specifically:
3. ☐ Claims Nos.:
because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

Box II Observations where unity of invention is lacking (Continuation of Item 2 of first sheet)

This International Searching Authority found multiple inventions in this International application, as follows:

1. ☐ As all required additional search fees were timely paid by the applicant, this International Search Report covers all searchable claims.
2. ☐ As all searchable claims could be searched without effort justifying an additional fee, this Authority did not invite payment of any additional fee.
3. ☐ As only some of the required additional search fees were timely paid by the applicant, this International Search Report covers only those claims for which fees were paid, specifically claims Nos.:
4. ☐ No required additional search fees were timely paid by the applicant. Consequently, this International Search Report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.:

Remark on Protest

- ☐ The additional search fees were accompanied by the applicant's protest.
- ☐ No protest accompanied the payment of additional search fees.

INTERNATIONAL SEARCH REPORT

 In Application No
 PCT/US 03/04139

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